U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 August 2004

Case No.: 2003-BLA-0127

In the Matter of:

LLOYD SATTERFIELD,
Claimant

v.

MIDWEST COAL COMPANY/AMAX COAL COMPANY,
Employer

RAG AMERICAN COAL COMPANY, on behalf of HORIZON NATURAL RESOURCES,
Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Sandra M. Fogel, Esq.
For the Claimant

Richard H. Risse, Esq.
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by Lloyd Satterfield for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901, *et seq.*, as amended ("Act"). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing.

[1] The Director, OWCP, was not represented at the hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of persons who were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment, and is commonly known as black lung.

A formal hearing in this case was held in Evansville, Indiana on December 11, 2003. Each of the parties was afforded full opportunity to present evidence and argument at the hearing as provided in the Act and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

The findings and conclusions that follow are based upon my observation of the appearance and the demeanor of the witness who testified at the hearing, and upon a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. Statement of the Case

The Claimant, Lloyd Satterfield, filed a second claim for black lung benefits pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, on May 19, 2000 (DX 1).[2] A Notice of Claim was issued on June 22, 2000, identifying Midwest Coal Co./Amex Coal Co., as the putative responsible operator (DX 5). On December 21, 2000, the Employer filed its Response to Notice of Claim (DX 19), and on December 29, 2000, the Employer filed its Controversion (DX 20). The District Director, OWCP, made an initial determination of entitlement (DX 30). The Employer requested a formal hearing and the claim was referred to the Office of Administrative Law Judges on May 22, 2001 (DX 39).

A hearing was held in Evansville, Indiana, on December 11, 2003, before the undersigned Administrative Law Judge. The record was held open 15 days for submission of deposition transcripts not yet received by the Employer (Tr. 16). The

[2] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's old Exhibits, "NEX" refers to the Employer's new Exhibits, and "Tr." refers to the transcript of the December 11, 2003 hearing.

record was held open 60 days to allow Dr. Cohen to respond to specific remarks in Employer's new Exhibits 14, 15, 16, and 17 (Tr. 12, 16). The record was held open 90 days for submission of briefs (Tr. 49).

Mr. Satterfield previously filed a claim on May 20, 1980, which was denied by the Director on September 18, 1980. Mr. Satterfield's appeal was dismissed on January 8, 1987, when he failed to attend an examination ordered by Judge Campbell. Mr. Satterfield did not establish any element of entitlement (DX 37).

II. Issues[3]

The Issues as listed on Form CM-1025 are as follows:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled;

4. Whether the Miner's disability is due to pneumoconiosis;

5. Whether the Miner has established a material change in conditions as required under § 725.309(c), (d); and,

6. The remaining issues set forth in paragraph 18, as well as the issues as to constitutionality of the Act and its regulations, are preserved for appeal purposes.

III. Findings of Fact and Conclusions of Law

The Claimant, Lloyd Satterfield, was born on October 9, 1923 (Tr. 45). He completed the eighth grade (DX 1, 37). The Claimant has no dependents for purposes of augmentation of benefits (Tr. 21).

[3] At the hearing, controversion was withdrawn to the Issues of timeliness, miner, responsible operator, dependency, and post-1969 employment. The parties stipulated to 15 years of coal mine employment (Tr. 17-18).

The Claimant testified that he smoked an average of 1½ packs of cigarettes per day from 1946 to 1980 (Tr. 42-44). This testimony is supported by the physician's records. I find, therefore, that the Claimant has a smoking history of about 35 years at a rate of 1½ packs of cigarettes per day, quitting around 1980.

Coal Mine Employment

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to determine the beginning and ending dates of coal mine employment by using any credible evidence.

On his application, the Claimant stated that he worked in coal mine employment for 15½ years (DX 1). At the hearing, the parties stipulated to 15 years of coal mine employment (Tr. 17).

The Claimant's Employment History form lists coal mine employment from 1947-1952 with King Mine and with Wabash Amax Mine from 1974-1985 (DX 2). The Claimant's FICA earnings worksheet shows employment with Princeton Mining for approximately five years, and with Amax from 1974-1979[4] (DX 37). A letter from Princeton King Mining confirms that Mr. Satterfield was employed by them for approximately 4.5 years (DX 37). I find that the Claimant has established 15 years of coal mine employment. On his Employment History, the Claimant stated that over the relevant period he was a roof bolter (DX 2).

The Claimant's last employment was in the State of Indiana; therefore, the law of the Seventh Circuit is controlling.

Responsible Operator

Midwest Coal Co./Amax Coal Co. has withdrawn it's challenge to the issue of responsible operator, and I find that Midwest Coal Co./Amax Coal Co. is properly named as responsible operator pursuant to §§ 725.494, 725.495 (Tr. 17-18).

IV. Medical Evidence

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standard
1.	03/03/03	NEX 13	Mathis	no cwp	Not listed

[4] The earnings report submitted only reported income through 1979.

2.	04/22/02	NEX 13	Mathis	no cwp	Not listed
3.	01/30/01	NEX 13	Wiot B reader[5] Board cert.[6]	0/0	Good

Comments: Single linear strand, upper right lung field, unrelated to coal dust exposure.

4.	01/30/01	DX 53	Wheeler B reader Board cert.	0/0	Fair

Comments: Decreased upper lung markings compatible with emphysema.

5.	01/30/01	DX 53	Scott B reader Board cert.	0/0	Fair

Comments: Possible emphysema and bullae apices.

6.	01/30/01	DX 36	Selby B reader	Comp. Neg.	Good

Comments: Lungs hyperinflated; evidence of old healed granulomatous disease; no evidence of pneumoconiosis; tiny non-obstructing left renal calculus.

7.	01/30/01	DX 46	Wichterman B reader Board cert.	1/0 s/t	Fair

Comments: S/T in all six zones; profusion 1/0; no significant pleural abnormalities.

[5] A "B reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2).

[6] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202(a)(ii)(C).

8.	01/30/01	DX 45	Cappiello B reader Board cert.	1/1 p/s	Good

Comments: No evidence of infiltrate; hyperinflation of lungs with changes of underlying chronic obstructive pulmonary disease; many small rounded opacities throughout both lungs; pneumoconiosis p/s/ 1/1; right and left chest wall pleural thickening.

9.	01/30/01	EX 1	Shipley B Reader Board cert.	Neg. cwp	Fair
10.	01/30/01	EX 2	Spitz B reader Board cert.	Neg. cwp	Fair
11.	01/30/01	EX 8	Renn B reader	Neg. cwp	Poor
12.	01/30/01	DX 45	Miller B reader Board cert.	1/1 p/s	Good

Comments: Multiple bilateral small round and irregular opacities; changes of chronic obstructive pulmonary disease.

13.	01/30/01	DX 44	Alexander B reader Board cert.	1/2 p/q	Good

Comments: Small primarily rounded opacities present bilaterally consistent with pneumoconiosis, p/q, 1/2.

14.	01/30/01	DX 45	Aycoth B reader	1/0 p/q	Good

Comments: Scattered rounded density opacities throughout both lungs; lungs well aerated and free of active disease; chronic obstructive pulmonary disease; pleural thickening; emphysema.

15. 01/30/01 DX 46 Sherrick 1/0 s/t Fair
B reader
Board cert.

Comments: Emphysematous changes in both lungs; small opacities in both lungs, distribution throughout all zones, greatest in mid and lower lungs; no pleural abnormalities seen; few scattered tiny post-inflammatory calcifications likely related to old granulomatous disease.

16. 06/27/00 DX 45 Miller 1/0 s/p Good
B reader
Board cert.

Comments: Multiple bilateral small irregular and round opacities; changes of chronic obstructive pulmonary disease; simple pneumoconiosis s/p, 1/0; thickening of minor fissure; slightly tortuous aorta.

17. 06/27/00 DX 44 Alexander 1/2 p/q Good
B reader
Board cert.

Comments: Small primarily round opacities present bilaterally, consistent with pneumoconiosis, category p/q 1/2.

18. 06/27/00 DX 42 Ahmed 1/1 p/q Good
B reader
Board cert.

Comments: Soft rounded parenchymal densities seen scattered throughout both lungs; changes of chronic obstructive pulmonary disease; thickening of the minor fissure; coalescence of small pneumoconiotic opacities; focal scarring in right apical region; simple pneumoconiosis p/q 1/1; emphysema.

19. 06/27/00 DX 42 Pathak 1/1 p/q Fair
B reader

Comments: Lungs hyperinflated due to chronic obstructive pulmonary disease; soft rounded parenchymal opacities scattered throughout all lung zones; small emphysematous bullae noted both lung apices; slight pleural thickening in the minor fissure on right side; pulmonary pneumoconiosis p/q 1/1.

20. 06/27/00 DX 45 Aycoth 1/0 p/q Good
B reader

Comments: Scattered rounded density opacities throughout both lungs; lungs free of active disease; changes of chronic obstructive pulmonary disease; pneumoconiosis; emphysema.

21. 06/27/00 DX 32 Shipley 0/0 Fair
B reader
Board cert.

Comments: Healed granulomatous disease; no pleural or parenchymal evidence of pneumoconiosis.

22. 06/27/00 DX 26 Spitz 0/1 Good
B reader
Board cert.

Comments: Q nodules in right upper zone, 0/1; nodular density overlying right third rib, possibly a calcified granuloma; no pleural disease.

23. 06/27/00 DX 27 Meyer 0/1 Good
B reader
Board cert.

Comments: Vague nodular opacities right apex Q and R size, profusion no greater than 0/1; negative for pneumoconiosis.

24.	06/27/00	DX 46	Sherrick B reader Board cert.	1/0 w/t	Fair

Comments: Emphysematous changes in both lungs; small opacities in both lungs, distribution throughout all zones, greatest in mid and lower lungs; no pleural abnormalities seen; few scattered tiny post-inflammatory calcifications likely related to old granulomatous disease.

25.	06/27/00	DX 35	Castle B reader	0/1 s/t	Fair
26.	06/27/00	DX 33	Renn B reader	0/0	Poor
27.	06/27/00	EX 8	Renn B reader	0/0	Poor
28.	06/27/00	DX 32	Fino B reader	Comp. Neg.	Good

Comments: No pleural and no parenchymal abnormalities consistent with occupational pneumoconiosis.

29.	06/27/00	DX 14	Sargent B reader Board cert.	0/0	Good

Comments: Widened aorta.

30.	06/27/00	DX 13	Gaziano B reader	0/0	Good

Comments: Severe calcified granuloma.

31.	06/27/00	DX 12	Cappiello B reader Board cert.	1/1 p/q	Good

Comments: Chronic obstructive pulmonary disease; scattered small rounded parenchymal opacities throughout both lungs; pneumoconiosis.

32. 06/27/00 DX 22 Wiot 0/1 Fair
B reader
Board cert.

Comments: Very few Q opacities right upper zone 0/1; ill defined nodular density overlying third rib, probably calcified not due to coal dust exposure, almost assuredly a granuloma; no evidence of coal workers' pneumoconiosis.

33. 06/27/00 DX 46 Wichterman 1/0 Good
B reader
Board cert.

Comments: Scattered fibronodular-type infiltrate in both lungs; parenchymal pattern consistent with S/T in all zones with a profusion of 1/0; no significant pleural abnormalities seen.

34. 06/27/00 NEX 14 Repsher 1/0 r/q Good
B reader

35. 07/12/99 DX 53 Wheeler 0/0 Fair
B reader
Board cert.

Comments: Minimal hyperinflation compatible with emphysema; few tiny scars or calcified granulomata in periphery lobes; no silicosis or cwp.

36. 07/12/99 DX 53 Scott 0/0 Poor
B reader
Board cert.

Comments: Hyperinflation lungs compatible with emphysema. Bullous emphysema right apex; calcified granuloma medial RLL.

37. 07/12/99 DX 49 Spitz 0/0 Good
B reader
Board cert.

Comments: Lungs over-expanded; linear strands in upper lobes; calcified granuloma right lower lung; no pleural disease; emphysema; no evidence of coal workers' pneumoconiosis.

38. 07/12/99 DX 48 Miller 1/1 s/p Good
B reader
Board cert.

Comments: Multiple bilateral small irregular and rounded opacities; changes of chronic obstructive pulmonary disease; pleural thickening pneumoconiosis category s/p 1/0; slightly tortuous aorta; small calcified granuloma.

39. 07/12/99 DX 48 Cappiello 2/2 p/t Good
B reader
Board cert.

Comments: No evidence of infiltrate; hyperinflation of lungs with changes of underlying chronic obstructive pulmonary disease; many small rounded and some irregular parenchymal opacities throughout both lungs; pneumoconiosis category p/t 2/2.

40. 07/12/99 DX 48 Ahmed 1/1 p/q Good
B reader
Board cert.

Comments: Parenchymal densities measuring up to 3 mm seen throughout both lungs; bullae noted; changes of chronic obstructive pulmonary disease; simple coal workers' pneumoconiosis category p/q 1/1; emphysema; indistinct diaphragm.

41. 07/12/99 DX 47 Wiot 0/0 Good
B reader
Board cert.

Comments: No evidence of coal workers' pneumoconiosis.

42. 07/12/99 DX 46 Whitehead 1/1, p/q Good
B reader
Board cert.

Comments: Lungs hyperextended. Scattered nodular opacities which may reflect mild change of pneumoconiosis; COPD.

43. 07/12/99 DX 49 Shipley 0/0 Good
B reader
Board cert.

Comments: Few small calcifications present in apices consistent with healed granulomatous disease; no pleural or parenchymal evidence of pneumoconiosis.

44. 07/12/99 NEX 13 Powers Not noted

Comments: No acute cardiopulmonary disease.

45. 09/07/99 DX 53 Wheeler 0/0 Poor
B reader
Board cert.

Comments: Minimal hyperinflation compatible with emphysema; few tiny scars or calcified granulomata in upper lobes; no silicosis or cwp.

46. 09/07/99 DX 46 Whitehead 1/1 p/q Good
B reader
Board cert.

Comments: Lungs hyperextended. Scattered nodular opacities which may reflect mild change of pneumoconiosis; COPD.

47. 09/07/99 DX 48 Ahmed 1/1 p/q Good
B reader
Board cert.

Comments: Rounded parenchymal densities scattered throughout both lungs; indistinct diaphragm; bullae noted; changes of chronic obstructive pulmonary disease; coalescence of small pneumoconiotic opacities; granuloma in mid lung field; fibrotic densities in lower lung fields; osteoporosis; focal scarring upper lung fields, more prominent on right.

48. 09/07/99 DX 48 Cappiello 2/1 p/t Fair
B reader
Board cert.

Comments: No evidence of infiltrate; hyperinflation of lungs with changes in chronic obstructive pulmonary disease; scattered small rounded and irregular parenchymal opacities throughout both lungs; pneumoconiosis category p/t 2/1.

49. 09/07/99 DX 48 Miller 1/0 s/p Good
B reader
Board cert.

Comments: Multiple bilateral small irregular and round opacities; changes of chronic obstructive pulmonary disease; pleural thickening; pneumoconiosis s/p 1/0; slightly tortuous aorta; small calcified granuloma.

50. 09/07/99 DX 47 Wiot 0/0 Good
B reader
Board cert.

Comments: No evidence of coal workers' pneumoconiosis; calcified granuloma at right base; lungs over-expanded consistent with emphysema.

51. 09/07/99 DX 53 Scott 0/0 Poor
B reader
Board cert.

Comments: Hyperinflation lungs compatible with emphysema; bullous change right apex; 5 mm calcified granuloma medial RLL; few smaller granulomata peripheral apices.

52. 09/07/99 DX 49 Shipley 0/0 Good
B reader
Board cert.

Comments: Few small calcifications present in apices consistent with healed granulomatous disease; no pleural or parenchymal evidence of pneumoconiosis.

53. 09/07/99 DX 49 Spitz 0/0 Good
B reader
Board cert.

Comments: Lungs over-expanded; linear strands in upper lobes; calcified granuloma right lower lung; no pleural disease; emphysema; no evidence of coal workers' pneumoconiosis.

54. 06/27/99 NEX 13 Powers Not listed

Comments: Probable small patchy non-specific right infrahilar infiltrate.

55. 09/22/97 NEX 13 Powers no cwp Not noted

Comments: Lung fields clear of active infiltrate.

56. 11/22/94 NEX 13 Mathis no cwp Not noted

Comments: No acute findings.

Pulmonary Function Studies

	Date	Exh.	Doctor	Age/Hgt.[7]	FEV_1	MVV	FVC	Standards
1.	01/30/01	DX 36	Selby	77/68"	1.23	34	2.47	Tracings included/ great difficulty cooperating
				Post-Bronch.	1.55	50	3.27	
2.	02/26/02	DX 43	Houser	78/66"	1.51	43.57	3.17	Tracings included/ coop./comp. not noted
				Post-Bronch.	1.64	47.80	3.38	

[7] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find the Miner's height to be 68".

3.	06/27/00	DX 8	Carandang	76/68"	1.30	40	2.84	Tracings included,
				Post-Bronch.	1.69	52	3.43	Good coop./ comp.

Dr. Tuteur found the MVV to be invalid because the breath volume was inappropriately low and inconsistent (DX 25).

Dr. Repsher opined that prebronchodilator readings did not reflect Claimant's true pulmonary function due to lack of full inspiration, but felt that post-bronchodilator values were valid (DX 24).

Dr. Renn invalidated the MVV readings due to no satisfactory MVV maneuvers performed (DX 23). Dr. Katzman found this study to be valid (DX 9).

4.	11/16/01	NEX 13	Murthy	78/69"	2.85	114	3.66	Tracings included/
				Post-Bronch.	1.49		2.98	Good coop./comp.

Arterial Blood Gas Studies

	Date	Exhibit	Physician	pCO_2	pO_2
1.	01/30/01	DX 36	Selby	38.1	83.7
2.	06/27/00	DX 11	Carandang	34.8	101.9
		Post-Exercise		36.9	95.1

Narrative Medical Evidence

1. Dr. Murthy, who was the Claimant's treating physician and who presents no medical specialty credentials, submitted treatment records for the Miner dated 2001 through 2003 (NEX 11). The records reflect consistent symptoms of shortness of breath, physical examinations showing occasional wheezing, and a consistent diagnosis of bronchitis and emphysema due to cigarette smoking. Dr. Murthy did not diagnose pneumoconiosis or COPD due to coal dust exposure in any of the records.

2. a. Dr. Jeff W. Selby, a Board-certified Internist, examined the Claimant on January 30, 2001 (DX 36; EX 11). Based on symptomatology (shortness of breath), employment history (+/- 15 years coal mine employment), individual and family histories, smoking history (50 pack years, quit 1979), physical examination (good air movement, no wheezes, rales, or rhonchi), chest x-ray (comp. negative), CT scan (negative), pulmonary function study (normal), arterial blood gas study (normal), and an EKG (abnormal), Dr. Selby diagnosed no pneumoconiosis or any respiratory or pulmonary abnormality or defect as a result of coal mine dust. He opined that the Claimant has "what appears

to be out of control asthma that just recently got better based on systemic steroids." He further noted some chronic obstructive pulmonary disease and significantly accelerated emphysema as a result of previous cigarette smoking.

b. Dr. Selby was deposed by the Employer on January 31, 2002, when he repeated the findings of his earlier written report (NEX 12). He noted that when he examined Mr. Satterfield, he recently had been prescribed steroids for his feet, which had a side effect of reducing the inflammation of his airways, allowing him to breath more easily. He said this is a typical asthma response to steroid use. He also noted three medicines being taken for breathing problems including an inhaler. The Miner complained that he got a choking sensation from cold air, smoke, dust, and perfumes and cleaners, all of which are significant for the typical asthmatic. He noted that Mr. Satterfield's father had asthma, and that asthma tends to be a familial disease. He noted that the Miner was on beta-blockers for his glaucoma, a medicine which would exacerbate asthma but not pneumoconiosis, adding support to his diagnosis. He opined that he has reviewed medical literature trying to connect coal mine dust with obstructive lung disease, and he found the arguments weak and unpersuasive.

3. a. Dr. Jerome F. Wiot, a Board-certified Radiologist and a B reader, interpreted a January 30, 2001 CT scan and opined that there was no evidence of coal workers' pneumoconiosis (NEX 1). He stated that the lung fields were overexpanded, which was consistent with emphysema. At the extreme right apex, there is a small area of old granulomatous disease, unrelated to coal dust exposure.

b. Dr. Wiot was deposed by the Employer on December 5, 2003, when he repeated the findings of his various x-ray and CT scan interpretations (EX 15).

4. Dr. Lawrence Repsher, a Board-certified Internist, Pulmonologist, Medical Examiner, Critical Care Specialist, and a B reader, submitted a January 8, 2001 letter reviewing the Claimant's June 27, 2000 pulmonary function study (DX 24). He opined that pulmonary function readings showed that Mr. Satterfield "is suffering from pure COPD, probably related to a long and heavy cigarette smoking history, but possibly related to severe underlying chronic bronchial asthma with airways remodeling. Evidence against the latter is the mildly reduced diffusing capacity, which would again suggest cigarette smoking rather than underlying asthma." He opined that the obstructive readings and borderline normal diffusing capacity

strongly suggest that the Claimant does not suffer from coal workers' pneumoconiosis.

5. Dr. Ralph T. Shipley, a Board-certified Radiologist and a B reader, reviewed a January 30, 2001 CT scan and submitted a written report (EX 1). He opined that there was no evidence of small or large rounded opacities that might be consistent with coal workers' pneumoconiosis. He noted mild to moderate upper zone predominant emphysema and clear lungs.

6. Dr. Harold B. Spitz, a Board-certified Radiologist and a B reader, reviewed a January 30, 2001 CT scan and submitted a written report (EX 2). He opined that the lungs were clear with no pleural disease. There was a thin linear strand at the right apex. No evidence of coal workers' pneumoconiosis. There are changes of emphysema.

7. a. Dr. David M. Rosenberg, a Board-certified Internist, Pulmonologist, Occupational Medicine Specialist, and a B reader, performed a September 4, 2003, records review at the request of the Employer (EX 2). He made an extensive review of the objective evidence of record. He noted coal mine employment of 15.5 years as a roof bolter and a smoking history of 40 years at a rate of up to two packs of cigarettes per day. The Claimant has a history of multiple exacerbations of asthma and chronic bronchitis, with multiple hospitalizations for these conditions. Dr. Rosenberg noted many nonpulmonary ailments including arthritis, esophageal reflux, prostatic hypertrophy, and various musculoskeletal complaints. Pulmonary function studies showed varying degrees of airflow obstruction over the years with a bronchodilator response. Blood gas readings were essentially normal. The majority of x-rays and CT scans were negative for micronodularity, but emphysema was noted. Dr. Rosenberg opined that with no restriction seen, normal diffusing capacity, with minimal clinical chest symptoms and negative x-ray evidence, Mr. Satterfield does not suffer from the interstitial form of coal workers' pneumoconiosis. Dr. Rosenberg stated that while the Miner has displayed varying degrees of airflow obstruction, he is now showing significant air trapping which would render Mr. Satterfield incapable of performing his previous coal mine job or a similarly arduous type of labor.

Dr. Rosenberg opined that COPD can often be associated with coal dust exposure. He explained that COPD associated with coal workers' pneumoconiosis begins focally in and around the coal macule. As the Miner's x-ray and CT scans demonstrated emphysema without the micronodularity associated with coal dust, it is improbable that the Miner's COPD was related to coal dust

exposure. He stated that pulmonary function tests that show increased total lung capacity and air trapping, with a marked bronchodilator response, strongly reinforces this opinion. He opined that the Miner's COPD is "undoubtedly" related to the Miner's long smoking history. Any other respiratory condition is attributable to asthmatic bronchitis. He opined that none of these conditions has been caused or hastened by coal dust exposure.

b. Dr. Rosenberg was deposed by the Employer on December 2, 2003, when he repeated the findings of his earlier written report (EX 17). Dr. Rosenberg testified that subsequent to his written report, he had the opportunity to review the newer reports from Drs. Renn, Cohen, and Talley and various hospital records in evidence. He opined that the newly reviewed evidence did not change his earlier report or opinions. He opined that the medical literature is consistent and clear that disabling COPD such as the type suffered by Mr. Satterfield cannot be caused by coal dust in the absence of a positive x-ray. He then reviewed the scientific tests and studies relied upon and how they supported and guided his diagnosis.

8. Dr. Christopher A. Meyer, a Board-certified Radiologist and a B reader, reviewed a January 30, 2001 CT scan and submitted a written report (EX 3). He opined that the lungs were hyperinflated with no fine irregular or nodular shadows. He diagnosed no radiographic evidence of coal workers' pneumoconiosis but diagnosed moderate emphysema and a calcified granuloma in right lower lobe. He did not list an etiology for the emphysema.

9. a. Dr. Peter G. Tuteur, a Board-certified Internist and Pulmonologist, performed an August 6, 2001 records review at the request of the Employer (EX 7). Dr. Tuteur reviewed the medical evidence of record dating from 1980 through 2001. He noted 15 years of coal mine employment and reviewed symptomatology. He opined that chest x-rays were regularly interpreted as free of coal workers' pneumoconiosis though unilateral upper lung field nodular densities are variously interpreted. CT scan showed old healed granulomatous disease and emphysema. He opined that the records reviewed produced

> … no convincing evidence whatsoever to indicate the presence of coal workers' pneumoconiosis of sufficient severity and profusion to cause symptoms, abnormal physical examination, impairment of pulmonary function, or abnormal radiographic studies. Mr. Satterfield does have cigarette smoke-induced chronic obstructive pulmonary disease manifested by

> daily cough and intermittent wheezing. … Mr. Satterfield clearly has other respiratory symptoms including cough, expectoration, wheezing often aggravated by irritants, and associated chest rightness. These findings are consistent with airflow obstruction. … Recognizing that cough, expectoration, wheezing and chest pain are not regular features of coal workers' pneumoconiosis, this symptom set strongly suggests the presence of cigarette smoke associated chronic obstructive pulmonary disease.

Dr. Tuteur opined that intermittent physical examinations and pulmonary function studies showing improvement with bronchodilator therapy reinforced a smoking etiology. Coal workers' pneumoconiosis is progressive and irreversible, and the fact that symptoms were intermittent weighs towards cigarette smoking and away from coal dust exposure as an etiology. Dr. Tuteur stated that because of cigarette-induced pulmonary impairment, glaucoma, and Mr. Satterfield's exercise intolerance, he is totally and permanently disabled from his usual coal mine work or work requiring similar effort. He opined that this disability was not due even in part to coal mine employment or coal dust exposure.

b. Dr. Tuteur was deposed by the Employer on January 29, 2002, when he repeated the findings of his earlier report (EX 16).

c. Dr. Tuteur was deposed by the Employer on December 8, 2003, when he supplemented his earlier responses (NEX 16). Dr. Tuteur reviewed Employer's New Exhibits 1 through 13 and Claimant's Exhibit 1 since the prior deposition. He opined that the newly reviewed records supported his earlier findings. Dr. Tuteur opined that Dr. Cohen misread or misunderstood the medical literature that he relied upon in making his diagnosis. Dr. Tuteur acknowledged that there is nothing in the records reviewed that can exclude the possibility that Mr. Satterfield's chronic obstructive pulmonary disease is due to the inhalation of coal mine dust, but he does not feel that coal dust was the proper etiology in this case.

10. a. Dr. Joseph J. Renn, a Board-certified Internist, Pulmonologist, Forensic Examiner, and a B reader, performed a September 5, 2001, records review at the request of the Employer (EX 8). Dr. Renn reviewed medical evidence dating from 1980 through 2001. He noted 15 years of coal mine employment, a smoking history of 40-80 pack years, reviewed personal and family medical histories, current medications, x-rays, pulmonary function studies, arterial blood gas studies, a January 30, 2001

CT scan, and physical examinations. Upon review, he diagnosed chronic bronchitis due to tobacco smoking with an asthmatic component, bullous emphysema owing to tobacco smoking, no pneumoconiosis, severe, significantly bronchoreversible obstructive ventilatory defect, and old pulmonary granulomatous disease. He opined that none of the above diagnoses were caused by, or contributed to, by the Claimant's exposure to coal mine dust. He stated that Mr. Satterfield is totally disabled from performing his last coal mine job or any similar work effort. He agreed with Dr. Selby that Mr. Satterfield's condition would improve considerably if the asthmatic component of his disease would be optimally treated.

b. Dr. Renn reviewed newer, additional records, and offered a November 9, 2003 supplemental report (NEX 4). He repeated his earlier diagnosis and reflected that the Miner suffers from a series of other nonpulmonary conditions unrelated to coal mine employment. His opinion was unchanged that all pulmonary ailments were the result of extensive smoking and not coal mine employment.

c. Dr. Renn was deposed by the Employer on December 4, 2003, when he repeated the findings of his earlier written reports (NEX 14). Dr. Renn opined that the bronchoreversibility of Mr. Satterfield's impairment is inconsistent with coal workers' pneumoconiosis. He noted the study cited by Dr. Cohen supporting a different finding, but opined that the literature cited by Dr. Cohen is flawed in the size of population studied and the lack of a large epidemiologic survey. He points out that if there was support for bronchodilators causing improvement in pneumoconiosis, there would be literature supporting the use of them as treatment for pneumoconiosis. Such literature does not exist. Dr. Renn agrees that the inhalation of coal mine dust can result in COPD and that the Miner's condition has progressed to the level of severe obstruction. He agreed that pulmonary function tests and arterial blood gas studies show the level of impairment but do not disclose the cause of the impairment. Dr. Renn opined that recurrent episodes of acute bronchitis would cause remottling of the airways that would, in turn, cause an irreversible component of the obstructive impairment. He also noted that the beta blocker eye medication taken by the Miner for glaucoma would exacerbate his obstructive airways disease. Dr. Renn believes that this is the cause of Mr. Satterfield's irreversible component of his obstructive lung disease.

11. a. Dr. Reynaldo Carandang, who presents no medical specialty credentials, examined the Claimant on June 27, 2000 (DX 10). Based on symptomatology (sputum, wheezing, dyspnea,

cough, hemoptysis, chest pain, ankle edema), employment history (16 years coal mine employment), individual and family histories, smoking history (38 years, 1-1½ packs per day, quit 1979), physical examination (high resonance, diminished breath sounds, few expiratory wheezes), chest x-ray, pulmonary function study, and arterial blood gas study, Dr. Carandang diagnosed coal workers' pneumoconiosis based on coal dust exposure and COPD based upon cigarette smoking. He opined that the Miner is totally disabled and stated that the "majority of symptoms are due to his coal mining employment and to a lesser degree his cigarette smoking, since he quit smoking many years ago."

b. Dr. Carandang submitted a November 1, 2000 letter to clarify his earlier written report (DX 16). He stated that his earlier diagnosis was based upon chest x-ray (as read by a B reader) and pulmonary function testing. He noted the Claimant's extensive smoking history but opined that since the Miner had not smoked in 21 years, and as pneumoconiosis is a progressive disease, Dr. Carandang stood by his earlier diagnosis of recurrent bronchitis and shortness of breath due to progressive clinical pneumoconiosis.

12. a. Dr. William C. Houser, a Board-certified Critical Care Specialist, Internist, and Pulmonologist, submitted a May 30, 2002 letter on behalf of the Claimant (DX 43; EX 10). He noted 18 years of coal mine employment, reviewed the working conditions endured by Mr. Satterfield, and opined that pulmonary function studies show moderately severe airway obstruction which would preclude the Claimant from performing the rigors of his prior coal mine job. "I believe his chronic obstructive pulmonary disease is related to cigarette smoking as well as exposure to coal and rock dust arising from his coal mine employment. I believe the factors causing his pulmonary disability are the chronic obstructive pulmonary disease and coal workers' pneumoconiosis."

b. Dr. Houser submitted a written report dated February 26, 2002 (DX 43). Dr. Houser noted the Claimant's past medical history and family history, 34 year smoking history of two packs of cigarettes per day, quitting in 1979, symptomatology of short of breath, cough, wheezing and sputum, x-ray (interpreted by Dr. Whitehead, 1/1), and seven years underground coal mine employment. Physical examination showed chest clear to percussion, diminished breath sounds, no rales, wheeze, pleural rubs, bronchial breath sounds, or rhonchi. Pulmonary function study showed moderately severe airway obstruction with some improvement after bronchodilator. Dr. Houser diagnosed: 1) chronic obstructive pulmonary disease – moderately severe; 2) coal workers' pneumoconiosis;

3) degenerative arthritis; 4) hypothyroid on replacement therapy; 5) benign prostatic hypertrophy; 6) peripheral neuropathy; 7) status post left knee replacement; 8) history of fractured left arm; 9) status post skin carcinoma; and, 10) status post left cataract. "I believe the etiology of his chronic obstructive pulmonary disease is related to his former cigarette smoking and also to former coal mine employment."

c. Dr. Houser submitted letters to Dr. Murthy dated July 1, 2003, April 1, 2003, October 20, 2002, and July 31, 2002 (NEX 10). The letters reported placing the Miner on home 0_2 and on bronchodilators. Dr. Houser consistently diagnoses severe airway obstruction, chronic obstructive pulmonary disease, and coal workers' pneumoconiosis.

13. Dr. Paul Wheeler, a B reader and a Board-certified Radiologist, examined a January 30, 2001 CT scan and opined that the scan showed no pneumoconiosis (DX 53). Dr. Wheeler noted minimal emphysema, minimal obesity, 5 mm calcified granuloma in lower RLL near spine, and tiny right paratracheal calcified granuloma compatible with healed histoplasmosis.

14. Dr. William W. Scott, a B reader and a Board certified Radiologist, reviewed a January 30, 2001 CT scan and noted emphysema, scattered bullae, few small calcified granulomata mediastinum and right hilum and one in RLL (DX 53). No evidence of silicosis or coal workers' pneumoconiosis.

15. a. Dr. Robert Cohen, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and a B reader, performed a November 21, 2003, records review at the request of the Claimant (CX 1). Dr. Cohen reviewed the objective evidence of record in detail and opined that the Miner suffers from coal workers' pneumoconiosis. He based his opinion on 15 years of established coal mine employment; symptoms consistent with chronic lung disease (including cough, sputum, dyspnea, and wheezing beginning as early as 1980); physical examinations since 1980 showing consistent increased breath sounds, increased percussion, and wheezing; 20 years of deteriorating pulmonary function readings showing obstructive lung disease; x-ray evidence that in his opinion was positive for pneumoconiosis; and, a smoking history which ended years before he started coal mine employment (and, therefore, was not likely to be a significant cause of the obstructive impairment). He further opined that the Miner's severe obstructive lung disease with diffusion impairment precludes Mr. Satterfield from engaging in the physical exertion required in his previous coal mine employment. He based his opinion on pulmonary function test results, and opined that the deteriorating pulmonary capacity of

the Miner was caused by both coal mine employment and previous cigarette smoking.

b. Dr. Cohen then reviewed the reports of Drs. Selby and Tuteur, stating that their method of associating all physical characteristics showing obstruction with smoking and those associated with restriction to coal dust exposure is too simple an explanation and not backed up by the scientific literature. He described in detail the scientific studies showing otherwise.

Dr. Cohen noted the response to bronchodilators in the pulmonary function studies, but stated that even with significant response, Mr. Satterfield's FEV_1 readings did not return to normal. He opined that this demonstrates that Mr. Satterfield has a partially reversible severe obstructive defect with a fixed, severe, permanent defect.

c. Dr. Cohen submitted a supplemental report on February 26, 2004, in response to the reports of Drs. Rosenberg and Tuteur (CX 2). Dr. Cohen disagreed with Dr. Rosenberg's opinion and stated that medical literature is clear that exposure to coal mine dust causes obstructive defects "which may span the whole range of impairment from minimal degrees of impairment to very important and clinically significant degrees of impairment." Diagnosis of this impairment is not dependent upon a positive x-ray interpretation.

> A reasonable diagnosis is based on consideration of a patient's medical picture and then application of sound medical principles found in the literature. Mr. Satterfield has significant work and smoking history, worsening of associated symptoms, positive chest x-rays, exercise limitation, and well-documented pulmonary function testing with abnormal values. Considering all the data and what we know from the literature, it is within medical certainty that both [smoking and coal dust exposure] contribute to his obstructive impairment and disability.

Dr. Cohen noted that Dr. Tuteur criticized Dr. Cohen's cited medical literature. Dr. Cohen believes in the medical literature and the scientific controls and methods utilized in the literature cited.

Treatment Records

The Employer submitted the treatment records of Dr. T.W. Talley, the Miner's ophthalmologist (NEX 5). Dr. Talley stated

that the Miner suffers from chronic open-angle glaucoma and that he has undergone previous cataract surgery.

Dr. Curtis Shinabarger, an Ear, Nose, and Throat Surgeon, submitted an August 28, 1996, letter and six pages of treatment notes (NEX 6). He noted symptoms of thick mucus in the mouth and nose. The Miner reported a smoking history of two packs per day for 40 years. Dr. Shinabarger saw no evidence of disease in the ears, nose, or throat.

Dr. Joseph Wolf, who lists no medical specialty credentials, submitted treatment notes from 2002 for treatment of burning sensations in the feet (NEX 7). Dr. Wolf made no pulmonary evaluations.

Dr. Jane Kim, a Dermatologist, submitted treatment notes for the Miner's treatment of skin cancer (NEX 8). She made no pulmonary evaluations.

Dr. William Vaughn, a Urologist, submitted treatment notes for the Miner's treatment for prostate and bladder problems (NEX 9). Dr. Vaughn made no pulmonary evaluations.

Hospitalization Records

The record contains 83 pages of newly submitted hospitalization records from Gibson General Hospital dated 1981-2001 (NEX 13). The records consistently diagnose COPD, emphysema, asthma, and almost continuous chronic bronchitis. There is a secondary diagnosis of coal workers' pneumoconiosis in the 1980's only, and treatment records for the entire 20-year period generally reflect x-rays with "no definite infiltrates."

V. Discussion and Applicable Law

The Claimant filed his black lung benefits claim on May 19, 2000 (DX 1). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.[8]

In order to establish entitlement to benefits in a living miner's claim pursuant to 20 C.F.R. § 718, the claimant must establish that he suffers from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the

[8] Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of § 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

pneumoconiosis is totally disabling. *See* 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.204; *Peabody Coal Co. v. Hill*, 123 F.3d 412, 21 B.L.R. 2-192 (6th Cir. 1997); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Material Change in Conditions

Under 20 C.F.R. § 725.309(d), "[i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the ground of the prior denial, unless the Deputy Commissioner determines that there has been a material change in conditions…." To demonstrate a "material change of conditions," it is not enough to introduce new evidence of disease or disability as this might only show that the first denial was wrong and would thereby be an impermissible collateral attack on the first denial. Rather, to prevail, a claimant must introduce evidence that demonstrates that his condition has "substantially worsened" since the time of the prior denial to the point that he would now be entitled to benefits. *NcNew v. Sahara Coal Co.*, 18 B.L.R. 3-524 (1993), *aff'd*, BRB No. 93-2189 BLA (Aug. 31, 1994) (unpublished). "To prevail in the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application." *Peabody Coal Co. v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997).

Mr. Satterfield's original May 20, 1980 claim was denied in 1987 because he failed to establish any element of entitlement. If the evidence does not support a material change in conditions on at least one element of entitlement, therefore, the duplicate claim must be denied as a matter of law.

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. The newly submitted record contains 56 interpretations of nine different chest x-rays.

The Board has held that an Administrative Law Judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-65 (1990), although it is within his or her discretion to do so, *Edmiston v. F&R Coal Co.*, 14 B.L.R. 1-65 (1990). However, "administrative factfinders simply cannot consider the quantity of evidence alone, without reference to a difference in the

qualifications of the readers or without an examination of the party affiliation of the experts." *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993).

Interpretations of B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *Vance v. Eastern Assoc. Coal Corp., Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); 8 B.L.R. 1-68 (1985). Physicians who are Board-certified Radiologists as well as B readers may be accorded still greater weight. *Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993).

The March 3, 2003 and the April 22, 2002 x-rays were read as negative by Dr. Mathis, who presents no specialty credentials in the interpretation of x-rays. I find that the March 3, 2003 and the April 22, 2002 x-rays are negative for pneumoconiosis. Given Dr. Mathis' lack of listed specialty credentials, I afford these x-rays some weight.

The January 30, 2001 x-ray was read as negative by five Board-certified Radiologists and B readers (*see* x-ray studies 3, 4, 5, 9, 10), as negative by two B readers (*see* x-ray studies 6, 11), as positive by five Board-certified Radiologists (*see* x-ray studies 7, 8, 12, 13, 15), and as positive by one B reader (*see* x-ray study 14). Given the equal qualifications of the interpreting physicians and a slight negative numerical superiority, I find that the January 20, 2001 x-ray evidence is negative for pneumoconiosis.

The June 27, 2000 x-ray was interpreted as negative by five Board-certified Radiologists and B readers (*see* x-ray studies 21, 22, 23, 29, 32), as negative by five B readers (*see* x-ray studies 25, 26, 27, 30), as positive by six Board-certified Radiologists and B readers (*see* x-ray studies 16, 17, 18, 24, 31, 33), and as positive by three B readers (*see* x-ray studies 19, 20, 34). I find that the six positive readings by Board-certified Radiologists and B readers outweigh the five negative readings by similarly qualified physicians. I find that the June 27, 2000 x-ray evidence is positive for pneumoconiosis.

The July 12, 1999 x-ray film was read as negative by five Board-certified Radiologists and B readers (*see* x-ray studies 35, 36, 37, 41, 43, 44), as negative by Dr. Powers, who presents no specialty credentials in the interpretation of x-rays (*see* x-ray study 44), and as positive by four Board-certified Radiologists and B readers (*see* x-ray studies 38, 39, 40, 42). I give greater weight to the five dually certified negative readings over the four dually certified positive readings, and

find that the July 12, 1999 x-ray evidence is negative for pneumoconiosis.

The September 7, 1999 x-ray film was read as negative by five Board-certified Radiologists and B readers (see x-ray studies 45, 50, 51, 52, 53), and as positive by four Board-certified Radiologists and B readers (see x-ray studies 46, 47, 48, 49). I give greater weight to the five dually certified negative interpretations over the four dually certified positive readings, and find that the September 7, 1999 x-ray evidence is negative for pneumoconiosis.

The June 27, 1999 x-ray film was read as negative by Dr. Powers, who presents no specialty credentials in the interpretation of x-rays. I find that the June 27, 1999 x-ray evidence is negative for pneumoconiosis, and noting Dr. Powers' lack of radiological credentials, I afford it some weight.

The September 22, 1997 x-ray film was read as negative by Dr. Powers, who presents no specialty credentials in the interpretation of x-rays. I find that the September 22, 1997 x-ray evidence is negative for pneumoconiosis, and noting Dr. Powers' lack of radiological credentials, I afford it some weight.

The November 22, 1994 x-ray was read as negative by Dr. Mathis, who presents no specialty credentials in the interpretation of x-rays. I find that the November 22, 1994 x-ray evidence is negative for pneumoconiosis and I afford his opinion some weight.

Taken as a whole, eight of the nine newly submitted record x-rays are negative for pneumoconiosis. The record contains 33 negative readings and 23 positive readings. The record reflects similar physician qualifications between the negative and positive readings. The preponderance of evidence does not support a finding of pneumoconiosis. I find that the existence of pneumoconiosis has not been established pursuant to 20 C.F.R. § 718.202(a)(1). The x-ray evidence does not establish a material change in condition on this element.

Section 718.202(a)(2) is inapplicable because there are no biopsy or autopsy results. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions are found to be applicable. In the instant case, § 718.304 does not apply because there is no x-ray, biopsy, autopsy, or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is not applicable to claims filed

after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

> (1) *Clinical Pneumoconiosis*. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

For a physician's opinion to be accorded probative value, it must be well reasoned and based upon objective medical evidence. An opinion is reasoned when it contains underlying documentation adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6th Cir. 1985). Further, a medical report may be rejected as unreasoned where the physician fails to explain how

his findings support his diagnosis. *See Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Selby, a Board-certified Internist, examined the Claimant on January 30, 2001, and opined that the Miner does not suffer from pneumoconiosis or any respiratory or pulmonary abnormality or defect as a result of coal mine employment. He based his opinion on a negative x-ray, negative CT scan, normal clinical evaluation of the chest, normal pulmonary function reading, and a normal blood gas study. He did diagnose chronic obstructive pulmonary disease and asthma based upon smoking. He based his smoking as opposed to coal dust exposure etiology on a 50 pack year smoking history, the breathing medications taken by the Miner, the positive effect of steroid use in shrinking the inflammation in his airways, and the Miner's sensitivity to cold air, dust, perfumes, and cleaners, all which would be significant for asthma, but not indicative of the permanent impairments caused by coal mine dust. He noted the familial history of asthma, and the Claimant's use of beta-blockers which would exacerbate asthma but not pneumoconiosis. He read the medical literature connecting coal mine dust with obstructive lung disease, but found the information reviewed to be unpersuasive and inapplicable to this case.

Dr. Selby's opinion is well reasoned. He utilized the objective evidence to build a diagnosis that the Miner does not suffer from pneumoconiosis. He explained how the data supported his findings, and then he added additional support through explanation of how the Miner's sensitivity to external irritants would be supportive of asthma while being inconsistent with pneumoconiosis. He reviewed the medical literature linking obstructive lung disease with coal mine dust and discussed how the literature was unsupportive in this case. Noting Dr. Selby's credentials as an Internist, I afford his opinion great weight against a finding of pneumoconiosis.

Dr. Wiot, a Board-certified Radiologist and a B reader, interpreted a January 30, 2001, CT scan and opined that there was no evidence of coal workers' pneumoconiosis. The Department of Labor has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920; 79, 945 (Dec. 20, 2000). Therefore, a CT scan, while arguably the most sophisticated and sensitive test available, must still be measured and weighed based upon the radiological qualifications of the reviewing physician. *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F.3d 885 (7th Cir. 2002). Dr. Wiot is a dually certified physician. While his negative reading on the CT scan cannot effectively rule out the existence of pneumoconiosis, I

afford his opinion great weight against a finding of pneumoconiosis.

Dr. Repsher, a Board-certified Internist, Pulmonologist, Medical Examiner, Critical Care Specialist, and a B reader, submitted a lengthy evaluation of the June 27, 2000 pulmonary function study, opining that the Miner suffers from COPD due to cigarette smoking and possibly bronchial asthma with airways remodeling. He opined that the data from the study was not supportive of pneumoconiosis. Dr. Repsher's opinion is based upon the objective pulmonary data. He explained how the numbers generated on the test supported his diagnosis. It is proper, however, to accord greater weight to an opinion which is supported by more extensive documentation over the opinion which is supported by limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984). Dr. Repsher presents superior credentials and a well-reasoned opinion. Noting that his entire opinion is supported by one pulmonary function study, however, I afford his opinion some weight against a finding of pneumoconiosis.

Dr. Shipley, a Board-certified Radiologist and a B reader, reviewed the January 30, 2001 CT scan and opined that the scan showed no evidence of small or large opacities consistent with pneumoconiosis. A CT scan must be measured and weighed based upon the radiological qualifications of the reviewing physician. *Consolidation Coal Co.*, *supra*. Dr. Shipley is a dually certified physician, and I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Spitz, a Board-certified Radiologist and a B reader, interpreted the January 30, 2001 CT scan and opined that there was no evidence of coal workers' pneumoconiosis. He did note emphysema. Noting Dr. Spitz's superior credentials as a dually qualified physician, I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Wheeler, a Board-certified Radiologist and a B reader, interpreted the January 30, 2001 CT scan and opined that it was negative for pneumoconiosis. He noted minimal emphysema and granuloma in the right side consistent with healed histoplasmosis. Noting Dr. Wheeler's superior credentials as a dually qualified physician, I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Scott, a Board-certified Radiologist and a B reader, reviewed the January 30, 2001 CT scan and noted emphysema, scattered bullae, a few small granulomata, and no evidence of silicosis or coal workers' pneumoconiosis. Noting Dr. Scott's

superior credentials as a dually qualified physician, I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Meyer, a Board-certified Radiologist and a B reader, interpreted the January 30, 2001 CT scan and opined that there was no evidence of coal workers' pneumoconiosis. He did note emphysema and calcified granuloma. Noting Dr. Meyer's superior credentials as a dually qualified physician, I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Rosenberg, a Board-certified Internist, Pulmonologist, Occupational Medicine Specialist, and a B reader, performed a records review at the request of the Employer. A nonexamining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984). Dr. Rosenberg opined that the Miner does not suffer from coal workers' pneumoconiosis. He based his opinion on pulmonary function tests showing no restriction, normal diffusing capacity, minimal clinical chest symptoms, and on negative x-ray and CT scan evidence. He diagnosed COPD related to cigarette smoking. He based his diagnosis on negative x-ray evidence of micronodularity and pulmonary function testing showing increased total lung capacity, air trapping, and a marked bronchodilator response. He opined that such responses showed that the COPD was attributable to asthmatic bronchitis as a result of cigarette smoking. He reviewed several medical studies and explained how they offered support and documentation to his findings.

Dr. Rosenberg's opinion is well reasoned. His opinion is based upon analysis of the objective evidence. He explained and documented his findings of no legal or clinical pneumoconiosis. He further supported his explanation with reference to and explanation of the medical studies relating obstructive defects to coal dust exposure. Noting Dr. Rosenberg's superior credentials, I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Tuteur, a Board-certified Internist and Pulmonologist, opined that x-ray evidence and CT scan evidence produced "no convincing evidence whatsoever to indicate the presence of coal workers' pneumoconiosis…." He opined that the Miner suffers from cigarette smoke-induced COPD. He based his smoking etiology on the nature of the symptoms – cough, wheezing, aggravation by other irritants, and chest pain – and explained that those symptoms are generally not regular features of coal workers' pneumoconiosis. He noted the irregularity and

inconsistent severity of symptoms and pulmonary function improvement with the use of bronchodilators as further support for his findings. He reviewed medical literature cited by Dr. Cohen and opined that Dr. Cohen had either misread or misunderstood the findings in the literature. He acknowledged that coal dust exposure could cause an obstructive defect, but opined that the data, literature, and objective evidence showed that a coal dust-induced COPD was unlikely in this case.

Dr. Tuteur's opinion is well reasoned. He makes use of the objective data to make his diagnosis, and then explains in detail how each piece of data supports and reinforces his conclusions regarding the etiology of the Miner's COPD. He reviewed the literature cited by Dr. Cohen and opined that he disagreed with Dr. Cohen's interpretation of those studies. Noting Dr. Tutuer's superior credentials, I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Renn, a Board-certified Internist, Pulmonologist, Forensic Examiner, and a B reader, diagnosed no pneumoconiosis. He diagnosed chronic bronchitis due to tobacco smoking with an asthmatic component, old pulmonary granulomatous disease, bullous emphysema, and severe, but significantly bronchoreversible obstructive ventilatory defect. He opined that the bronchoreversibility shown in the pulmonary function studies was inconsistent with coal workers' pneumoconiosis. He reviewed the literature cited by Dr. Cohen and opined that the study cited contained quality flaws that made the data unreliable and unusable. He noted that ongoing, recurrent bouts of chronic bronchitis would cause remottling of the upper airways, which would, in turn, cause the irreversible component of the obstructive impairment that Dr. Cohen attributed to coal dust inhalation. He also noted that the glaucoma medicine used by the Miner would exacerbate the obstruction of his airways. Taken as a whole, all of these factors pointed to a smoke-induced etiology and none of them suggested a coal dust inhalation etiology.

Dr. Renn's opinion is well reasoned. Dr. Renn reviewed the objective evidence to form his diagnosis. He documented his findings with specific symptoms and test results that explained how the data supported his diagnosis. Given Dr. Renn's superior credentials, I afford his opinion substantial weight against a finding of pneumoconiosis.

Dr. Carandang, who presents no medical specialty credentials, opined that the Miner suffers from coal workers' pneumoconiosis based upon x-ray evidence, coal dust exposure history, and symptoms, and from COPD caused by cigarette smoking

as evidenced through pulmonary function results. He opined that since the Miner had quit smoking over 20 years ago and as pneumoconiosis is a progressive disease, the symptoms causing chronic bronchitis and shortness of breath were due to progressive clinical pneumoconiosis.

A report is properly discredited where the physician does not explain how underlying documentation supports his diagnosis. *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982). Dr. Carandang's report does not list which testing results were relied upon in forming his opinion. Likewise, he fails to explain how the unlisted data supports his diagnosis and etiology findings. While he notes the Miner's cessation of smoking and the progressive nature of pneumoconiosis, he fails to provide any documentation or support for his bare conclusion that the pulmonary impairments diagnosed were caused by coal mine employment. Noting Dr. Carandang's lack of specialty credentials, I afford his opinion less weight.

Dr. Houser, a Board-certified Internist, Pulmonologist, and Critical Care Specialist, opined in 2002 that the Miner suffers from chronic obstructive pulmonary disease and from coal workers' pneumoconiosis. He based his coal workers' pneumoconiosis diagnosis on a positive x-ray (as interpreted by Dr. Whitehead, a B reader). He based his COPD diagnosis on pulmonary function tests and opined that the etiology of the COPD was both coal dust exposure and cigarette smoke.

The Board holds permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). Dr. Houser's 2002 coal workers' pneumoconiosis diagnosis is based on a positive x-ray interpretation. With no further analysis or data to support or explain his diagnosis, I find that Dr. Houser's coal workers' pneumoconiosis diagnosis is no more than an x-ray reading restatement, and I afford it less weight.

Dr. Houser's COPD diagnosis is also not well reasoned. While he bases his diagnosis on a February 26, 2002, pulmonary function study (*see* DX 43), the study does not list the cooperation or comprehension of the Claimant, making it nonconforming. Dr. Houser fails to explain or interpret the improvement in pulmonary function shown after bronchodilation. He notes symptoms reported by the Claimant of shortness of breath, cough, and wheezing, but fails to find any of those symptoms upon examination of the chest. He fails to explain how

cigarette smoking and coal mine employment were both causing the COPD now diagnosed. I afford his opinion less weight.

Dr. Cohen, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and a B reader, performed a records review and opined that the Miner suffers from coal workers' pneumoconiosis. He based his diagnosis on length of coal mine employment, symptoms consistent with chronic lung disease, clinical evaluations of the chest which corroborated the symptoms reported, x-ray evidence, and a pulmonary function test showing obstructive lung disease. He listed the etiology of the obstructive lung disease as both cigarette smoking and coal dust exposure.

Dr. Cohen provided a long discussion of his diagnosis, utilizing scientific literature, and he reviewed and answered the criticisms of Drs. Selby, Rosenberg, and Tuteur. His opinion was that associating all physical characteristics showing obstruction with smoking, and those associated with restriction to coal dust exposure, was too simple an explanation and that such a complete separation was not supported by the literature that he reviewed. Dr. Cohen also offered explanation for how pulmonary improvement after application of bronchodilators was consistent with his findings.

Dr. Cohen utilized the objective evidence to make his diagnosis. He supported his findings with test data and scientific literature. He documented his findings and offered explanation for criticisms to his diagnosis. Noting Dr. Cohen's superior credentials, I afford his opinion great weight in support of pneumoconiosis.

The treatment records submitted by the Employer focus on nonpulmonary conditions and do not evaluate the presence or absence of pneumoconiosis. An opinion which is silent on an issue is not probative of that issue. *See, e.g., Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). The treatment records offer no opinion on legal or clinical pneumoconiosis and I afford them no probative weight on this issue.

The record contains 83 pages of hospitalization records dated 1981-2001. The records consistently diagnose COPD, emphysema, asthma, and 20 years of almost continuous chronic bronchitis. There is a secondary diagnosis of coal workers' pneumoconiosis in the 1980's only, and treatment records for the entire 20-year period generally reflect x-rays with "no definite infiltrates."

Taken as a whole, Drs. Selby, Rosenberg, Tuteur, and Renn, all possessing superior credentials, provide well-reasoned opinions, based upon objective medical evidence, that the Claimant does not suffer from pneumoconiosis as defined in § 718.201. This finding is supported by the opinion of Dr. Repsher (who based his opinion on limited objective data) and by six negative CT scan interpretations by Board-certified Radiologists and B readers. These opinions are also consistent with hospitalization records showing chronic bronchitis, emphysema, and asthma. The opinion of Dr. Cohen, while well reasoned, is outweighed by the other opinions of record. Accordingly, I find that the Claimant has not established the existence of pneumoconiosis under § 718.202(a)(4).

The Claimant has failed to establish a material change in conditions on the issue of pneumoconiosis pursuant to § 725.309(d).

Causal Connection Between Pneumoconiosis and Coal Mine Work

Because the Claimant has not established pneumoconiosis, the question of whether it is caused by his coal mine employment is moot. Moreover, even though the evidence establishes more than 10 years of coal mine work, any presumption of a causal connection with coal mine employment is more than adequately rebutted by the medical opinion evidence discussed above. Therefore, the evidence fails to establish this element of the claim or a material change in conditions.

Total Disability

Since the Miner does not have pneumoconiosis, his claim cannot succeed. Had he established the existence of the disease, the evidence does not show that he had a totally disabling respiratory or pulmonary ailment which could be attributed to pneumoconiosis. Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. Section 718.204(b)(1)(i) and (ii). The Claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *See, e.g., Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 test results are divided by the FVC test results.

The record contains four pulmonary function studies. The fact-finder must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steep Corp.*, 9 B.L.R. 1-131 (1986). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). Little or no weight may be accorded to a ventilatory study where the miner exhibited poor cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547 (1981).

The January 30, 2001 pulmonary function study noted that the Claimant had great difficulty cooperating with the test. Understanding was not listed. I equate "great difficulty" with poor ability to cooperate and find that the January 30, 2001 pulmonary study is invalid and, therefore, nonprobative.

The November 16, 2001 study was conforming and produced nonqualifying readings.

The June 27, 2000 MVV reading was invalidated by Drs. Tuteur and Renn. I find the remaining values to be valid

and find that the June 27, 2000 study produced qualifying readings.

The February 26, 2002 pulmonary study is conforming and contains qualifying readings.

Taken as a whole, there are three valid pulmonary function studies. One is nonqualifying and two are qualifying. I find that the preponderance of newly submitted pulmonary function evidence supports total disability.

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The newly submitted record contains two arterial blood gas studies. All newly submitted arterial blood gas results are nonqualifying.

There is no evidence presented, nor do the parties contend that the Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

Under § 718.204(b)(2)(iv) total disability may be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work. The CT scan reports of Drs. Wiot, Shipley, Meyer, Wheeler, and Scott do not address the issue of total disability, and those opinions are afforded no probative weight on the issue of total disability. Likewise, the hospitalization and treatment records make no disability finding and offer no probative evidence on this element.

Dr. Selby, a Board-certified Internist, opined that the Miner does not suffer from any respiratory or pulmonary defect or abnormality as a result of coal mine dust. He based that opinion on a normal physical examination of the chest, normal pulmonary function exam, negative x-ray and normal arterial blood gas readings. Dr. Selby based his opinion on the objective evidence. He supported his diagnosis through alternative diagnoses that were better supported by the evidence and by a discussion of the medical literature. I find Dr. Selby's opinion well reasoned. Noting his credentials, I afford his opinion great weight against a finding of total disability.

Dr. Rosenberg, a Board-certified Internist, Pulmonologist, Occupational Medicine Specialist, and a B reader, opined that the Miner has COPD and significant air trapping that would

prevent him from performing his previous coal mine job or a similarly arduous type of labor. He based his diagnosis on negative x-ray and CT scans, pulmonary function testing showing varying degrees of obstruction with response to bronchodilators, normal clinical chest evaluations, normal arterial blood gas readings, and a 60+ pack year smoking history. He opined that the COPD diagnosed was totally due to cigarette smoking and not due to coal mine employment. He opined that a marked bronchodilator response, x-rays showing no micronodularity normally associated with coal dust, and the medical literature all strongly suggested that the obstructive defect seen was not due to coal dust exposure.

Dr. Rosenberg's opinion is well reasoned. He based his diagnosis on objective data and then explained how the abnormal testing reflected a smoking etiology instead of a coal dust etiology. He then utilized medical literature to further document his findings. Noting Dr. Rosenberg's superior credentials, I afford his opinion great weight supporting total pulmonary disability but not supporting disability due to pneumoconiosis.

Dr. Tuteur, a Board-certified Internist and Pulmonologist, diagnosed total pulmonary disability due to cigarette-induced pulmonary impairment, glaucoma, and exercise intolerance. He based his opinion on negative chest x-rays and CT scans and on symptoms and chest examinations that showed cough and wheeze and chest pain, which are not regular features of coal workers' pneumoconiosis but regularly appear in individuals suffering from smoke-associated chronic obstructive pulmonary disease. Pulmonary function studies showed intermittent and variable obstruction and showed marked improvement with bronchodilators suggesting a smoking etiology. He opined that while it was possible that the Miner's COPD was due, in part, to the inhalation of coal dust, the data did not support such a diagnosis in this case. He reviewed the literature used by Dr. Cohen and opined that Dr. Cohen either misread or misunderstood the literature cited.

Dr. Tuteur's opinion is well reasoned. He based his opinion on the objective testing and he explained how the results of those tests supported his smoking etiology. He further addressed the contrary medical literature provided by Dr. Cohen. Noting Dr. Tuteur's superior credentials, I afford his opinion great weight supporting total pulmonary disability but not supporting total disability due to pneumoconiosis.

Dr. Renn, a Board-certified Internist, Pulmonologist, Forensic Examiner, and a B reader, opined that Mr. Satterfield

is totally disabled from performing his last coal mine employment. He based his opinion on pulmonary function studies showing deterioration of pulmonary ability to the point where the Miner now suffers from severe obstruction. He then noted that pulmonary improvement with bronchodilators strongly suggest a smoking etiology. He opined that the Miner also suffers from asthma and that if the asthmatic component of the Miner's ailments was optimally treated, he would see some improvement. Dr. Renn noted that the beta-blocker used to treat the Miner's glaucoma also would exacerbate the Miner's obstructive airways disease.

Dr. Renn's opinion is well reasoned. He utilized the pulmonary function testing over an extended period of time to show deterioration of pulmonary function to the point of severe obstruction. He explained his findings and he listed reasons for his smoking etiology, and he listed complicating factors (asthma and beta-blockers) which would exacerbate the Miner's obstructive airways disease. Noting Dr. Renn's superior credentials, I afford his opinion great weight in support of total pulmonary disability, but not supporting total disability due to pneumoconiosis.

Dr. Carandang, who presents no medical specialty credentials, opined that the Miner is totally disabled, and opined that the "majority of symptoms are due to his coal mining and to a lesser degree his cigarette smoking, since he quit smoking many years ago." He based his disability finding on pulmonary function testing. He opined that the Miner's disability was mostly due to pneumoconiosis because pneumoconiosis is a progressive disease and the Miner quit smoking over 20 years ago, thus limiting the impact of cigarette smoking.

Dr. Carandang's opinion is not well reasoned. The June 27, 2000 pulmonary function test relied upon had the MVV readings invalidated by several physicians. With invalid MVV readings, the pulmonary function test relied upon is nonqualifying. He fails to address the Claimant's improvement with bronchodilators, which every other credible physician noted as an important indicator of the etiology of the total disability. While he opines that pneumoconiosis is progressive, he fails to demonstrate that it has progressed in this instance, with this Claimant. Finally, he fails to address why a 50+ pack year smoking history would not be the major component of the Miner's obstruction, even with consideration given to the cessation of smoking in 1979. Noting Dr. Carandang's lack of medical specialty credentials, I afford his opinion less weight.

Dr. Houser, a Board-certified Internist, Pulmonologist, and a Critical Care Specialist, opined that pulmonary function studies show moderately severe airway obstruction which would preclude the Claimant from performing the rigors of his prior coal mine employment. He listed the etiology of the airway obstruction as cigarette smoking and coal dust exposure. Dr. Houser did not explain his etiology determination, nor did he explain how the Miner's response to bronchodilators affected his etiology determination. He did not address the possibility of asthma, did not diagnose emphysema, and did not address the potential effects of the Miner's glaucoma medications on the Miner's symptoms. I find Dr. Houser's opinion on total disability unsupported, not well reasoned, and I afford it less weight.

Dr. Cohen, a Board-certified Internist, Pulmonologist, Critical Care Specialist, and a B reader, opined that the Miner's severe obstructive lung disease with diffusion impairment precludes Mr. Satterfield from engaging in the physical exertion required of his previous coal mine employment. He based his opinion on 20 years of deteriorating pulmonary function readings. He listed the etiology of the disability as both smoking and coal dust exposure. He reviewed the other opinions of record and stated that associating all physical characteristics showing obstruction with smoking was too simple an explanation for determining the etiology of the Miner's total disability. He reviewed medical literature showing that coal dust can cause an obstructive defect. He explained that bronchodilators improved only part of the Miner's pulmonary function, thereby inferring that at least part of his impairment was severe and fixed in nature. He reviewed the opinions of other physicians who criticized his diagnosis and the medical literature cited by Dr. Cohen. He disagreed with the physicians who found quality problems with the medical literature cited and opined that his determination remained unchanged in light of their criticisms.

Dr. Cohen's opinion is well reasoned. He based his disability finding on a 20-year history of deteriorating physical examinations and pulmonary function readings. He explained how he came to a mixed smoking/coal dust etiology and supported his opinion with medical literature. Noting Dr. Cohen's superior credentials, I afford his opinion great weight supporting total pulmonary disability due to pneumoconiosis.

As a result of qualifying pulmonary function testing, normal blood gas testing, and the well-reasoned opinions of Drs. Rosenberg, Tuteur, Renn, and Cohen that the Claimant

suffers from total pulmonary or respiratory disability, I find that the newly submitted evidence establishes total pulmonary disability. I find, however, that the well-reasoned smoking etiology explanations offered by Drs. Rosenberg, Tuteur, and Renn, outweigh the contrary coal dust etiology opinion offered by Dr. Cohen. I find, therefore, that the Miner has failed to establish that his total pulmonary disability is due to pneumoconiosis under § 718.204(b)(2).

Having established total pulmonary disability, I find that the Miner has shown a material worsening of his condition and, accordingly, has established a material change in conditions. A full review of the evidence, however, does not show that the Miner suffers from pneumoconiosis arising out of coal mine employment or that the Miner's total pulmonary disability arose, in part, from his pneumoconiosis.

VI. Entitlement

Lloyd Satterfield, the Claimant, has not established entitlement to benefits under the Act.

VII. Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claim of Lloyd Satterfield for benefits under the Act is hereby DENIED.

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Robert L. Hillyard
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A

copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.